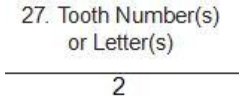
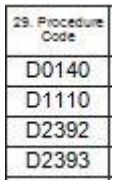
ADA 2012 CLAIM FORM INSTRUCTIONS

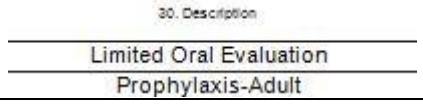
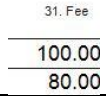
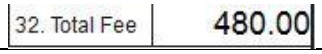
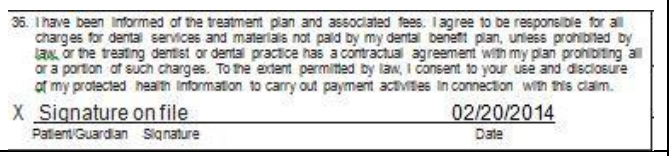
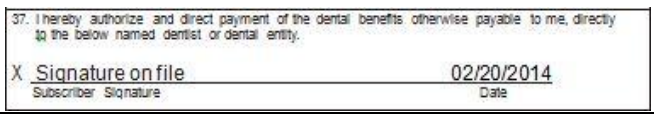
FIELD NUMBER	FIELD NAME	INSTRUCTIONS
1	Type of Transaction	Enter an "X" in the appropriate box. 1. Type of Transaction (Mark all applicable boxes) ☒Statement of Actual Services ☐ Request for Predetermination/Preauthorization
2	Not Required	
3	Insurance Company Plan	Enter the plan name (RI Medicaid), address, state and zip code. 3. Company/Plan Name, Address, City, State, Zip Code HP Enterprise Services – RI Medicaid P.O. Box 2010 Warwick, RI 02887-2010
4	Other Coverage	Check the appropriate box. If either box is checked, complete fields 5 through 11(*gray section). If no box checked, skip to field 12.* **OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.) 4. Dental? ☒ Medical? (If both, complete 5-11 for dental only.)
5	Name of Policy Holder	Enter last, first name and middle initial of policy holder. 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) Jones, Mary A
6	Date of Birth	Enter the date of birth of policy holder in MMDDCCYY format. 6. Date of Birth (MM/DD/CCYY) 10/05/1978
7	Gender	Check the appropriate box for gender of policy holder. 7. Gender ☐M ☒F
8	Policy Holder ID	Enter subscriber information. 8. Policyholder/Subscriber ID (SSN or ID#) ABC123456
9	Plan/Group Number	Enter policy or group number. 9. Plan/Group Number DEF789123

10	Patient's Relationship to Insured	Check appropriate box. 10. Patient's Relationship to Person named in #5 ☐Self ☒Spouse ☐ Dependent ☐ Other
11	Other Insurance Company	Enter the three digit carrier code and name of any other insurance the patient has. Note: The other insurance carrier must be billed first. 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code 22T - American Dental
12	Policy Holder	Enter RI Medicaid policy holder name and address - *optional*
13	Date of Birth	Enter the date of birth of policy holder in MMDDCCYY format - *optional*
14	Gender	Check appropriate box - *optional*
15	Policy Holder ID	Enter RI Medicaid identification number. 15. Policyholder/Subscriber ID (SSN or ID#) 123-45-6789
16	Plan Number	Enter plan number- *optional*
17	Employer Name	Enter the name of employer *if applicable*
18	Relationship to Policy Holder	Check appropriate box - *optional*
19	Reserved for Future Use	
20	Patient's Name and Address	Enter last name, first and middle initial of patient as it is displayed on their RI Medicaid ID card. Enter the street, city and zip code of the patient. 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Jones, James, P 123 Main St. Providence, RI 02901
21	Date of Birth	Enter the date of birth of patient in MMDDCCYY format. 21. Date of Birth (MM/DD/CCYY) 03/23/1973
22	Gender	Check appropriate box. 22. Gender ☒M ☐F
23	Patient ID	Enter patient account number (as assigned by provider) - *optional*
24	Procedure Date	Enter the date for this service in MMDDCCYY numeric format. 24. Procedure Date (MM/DD/CCYY) 06/22/2014
25	Not Required	

<table>
<tr><td>26</td><td>Not Required</td><td></td></tr>
<tr><td>27</td><td>Tooth Number</td><td>Enter the appropriate tooth number or letter.
When the procedure directly involves a tooth or range of teeth, enter tooth number(s) 1-32 for permanent dentition, 51-82 for supernumerary teeth, A-T for primary dentition or AS-TS for primary supernumerary teeth.
If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form.
When reporting a range of teeth, use a hyphen “-“ to separate the first and last tooth in the range (e.g., 1-4, 7-10, 22-27), or use commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10, 3-5, 22-27). To report a quadrant, enter UL, UR, LL or LR.
  </td></tr>
<tr><td>28</td><td>Tooth Surface</td><td>When applicable, enter a tooth surface code.
Enter the 1 digit code for the tooth surface.

<table><tr><th>Code</th><th>Surface</th></tr><tr><td>B</td><td>Buccal</td></tr><tr><td>D</td><td>Distal</td></tr><tr><td>F</td><td>Facial</td></tr><tr><td>I</td><td>Incisal</td></tr><tr><td>L</td><td>Lingual</td></tr><tr><td>M</td><td>Mesial</td></tr><tr><td>O</td><td>Occusal</td></tr></table></td></tr>
<tr><td>29</td><td>Procedure Code</td><td>Enter the 5 character ADA CDT code that describes each procedure performed.
PA instructions: Enter the procedure code of the requested service.

  </td></tr>
</table>

29a	Not Required	
29b	Quantity	Enter the number of times (01-99) that the procedure in field 29 is delivered to the patient on the date of service in field 24. 
30	Description	Enter description of procedure performed or procedure for which PA is being requested. 
31	Fee	Enter your usual and customary charge for each procedure. 
31a	Not Required	
32	Total Fee	The sum of all fees from field 31, plus any fees in field 31a. 
33	Not Required	
34	Not Required	
34a	Not Required	
35	Not Required	
36	Authorization	Patient/guardian signature or “signature on file”. Enter date signature was acquired. 
37	Authorization	Subscriber signature or “signature on file”. Enter date signature was acquired. 

<table>
<tr><td>38</td><td>Place of Treatment</td><td>Enter the two digit place of service code for professional claims, a HIPAA standard. Frequently used codes are:<table><tr><th>Code</th><th>Location</th></tr><tr><td>11</td><td>Office</td></tr><tr><td>12</td><td>Home</td></tr><tr><td>21</td><td>Inpatient Hospital</td></tr><tr><td>22</td><td>Outpatient Hospital</td></tr><tr><td>31</td><td>Skilled Nursing Facility</td></tr><tr><td>32</td><td>Nursing Facility</td></tr><tr><td></td><td></td></tr></table>38. Place of Treatment 11</td></tr>
<tr><td>39</td><td>Not Required</td><td></td></tr>
<tr><td>40</td><td>Not Required</td><td></td></tr>
<tr><td>41</td><td>Not Required</td><td></td></tr>
<tr><td>42</td><td>Not Required</td><td></td></tr>
<tr><td>43</td><td>Not Required</td><td></td></tr>
<tr><td>44</td><td>Not Required</td><td></td></tr>
<tr><td>45</td><td>Treatment Resulting From</td><td>If treatment is from accident or injury, mark the appropriate box.
45. Treatment Resulting from
☐Occupational illness/injury ☒ Auto accident ☐ Other accident</td></tr>
<tr><td>46</td><td>Date of Accident</td><td>Complete date in MMDDCCYY format if any box checked in field 45.
46. Date of Accident (MM/DD/CCYY) 06/20/2014</td></tr>
<tr><td>47</td><td>Auto Accident State</td><td>Enter the state of accident if auto accident noted in field 45.
47. Auto Accident State RI</td></tr>
<tr><td>48</td><td>Billing Dentist</td><td>Enter the billing dentist name, address, and zip code.
48. Name, Address, City, State, Zip Code
James Smith DDS
456 Post Rd.
Cranston, RI 02910</td></tr>
<tr><td>49</td><td>NPI</td><td>Enter the NPI for the billing entity. If group, enter the group NPI.
49. NPI
1234567890</td></tr>
<tr><td>50</td><td>License Number</td><td>Enter taxonomy code corresponding to the NPI in field 49.
50. License Number
122300000X</td></tr>
</table>

51	SSN or TIN	Enter social security number or TIN of the billing provider. 51. SSN or TIN 123121234
52a	Not Required	
53	Signature	**Enter the original authorized signature of the billing provider or supplier. (Stamps or initials are not acceptable.) Also enter the date the claim was signed.** 53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X Jake Jones, DDS 06/20/2014 Signed (Treating Dentist) Date
54	NPI	Enter the NPI of the treating dentist. *Required if a member of a group.*
55	License Number	Enter the treating provider license number.
56	Address	Enter address at which the services were rendered *if different than field 48.*
56a	Provider Specialty Code	Enter the corresponding taxonomy to the NPI entered in field 54.
57	Phone Number	Enter the phone number of treating dentist if different than field 52.
58	Not Required	